SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
Company Tracking Number:	*AR0055900004*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Hospital Indemnity*		
Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Hospital Indemnity	SERFF Tr Num: AEGX-G126708376	State: Arkansas
TOI: H02G Group Health - Accident Only	SERFF Status: Closed-Approved-Closed	State Tr Num: 46138
Sub-TOI: H02G.000 Health - Accident Only	Co Tr Num: AR0055900004	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 08/03/2010
	Date Submitted: 07/06/2010	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Hospital Indemnity
Project Number: AR0055900004
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/03/2010

Deemer Date:
Submitted By: SPI ADMSLH
Filing Description:
Stonebridge Life Insurance Company
NAIC: 0468-65021
FEIN: 03-0164230
RE: SLHAP1000GP Group Accident Indemnity Policy
SLHAP1000GC.AR Group Accident Indemnity Certicate
SLHAP1000GE.AR Enrollment Form
Actuarial Memorandum

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Discretionary
Explanation for Other Group Market Type:
State Status Changed: 08/03/2010
Created By: SPI ADMSLH
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
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TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Hospital Indemnity*		
Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Enclosed for your review and approval is out-of-state group hospital indemnity certificate SLHAP1000GC.AR. This form is new and is not intended to replace any previously approved form. The form is completed in "John Doe" fashion. Variable information is printed and bracketed in red.

The group policy, form SLHAP1000GP, was approved by the Missouri Department of Insurance on May 5, 2010. The controlling group policy is contemplated for issue to various discretionary groups that are sitused in Missouri. The policy will initially be issued to National Financial Institutions Group Insurance Trust which is a participating group trust comprised of banks and financial institutions.

Group Certificate SLHAP1000GC,AR provides a benefit for daily hospital confinement due to an accident resulting in an injury. Additional indemnity benefits include Accident Daily Intensive Care Unit Benefit that pays if the covered person is confined to an intensive care unit; an Accident Daily Outpatient Benefit that pays for necessary treatment in a hospital emergency room or other outpatient facility; an accident daily physician visit benefit that pays for physician visits for follow up treatment after an injury and an Accident Ambulance Benefit which pays for transportation to or from a hospital facility.

Coverage is guaranteed issued and guaranteed renewable to age 100.

Enclosed is an Actuarial Memorandum in support of this product.

The company has reviewed the enclosed forms and certifies that each form submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

We request approval of the submitted forms in various dimensions, format, shading and colors. No dimension/format/shading/color change would produce unacceptable print. The referenced form may be used in other media formats including translations into (Spanish, Chinese, Korean, Vietnamese, Polish, etc) and in such case, we certify the content will not change.

This product will be mass marketed by direct mail, telemarketing and possibly on the Internet through our website.

Company and Contact

Filing Contact Information

Sam Hunt, Manager, Product Filing & Compliance	shunt@aegonusa.com
300 Eagleview Boulevard	610-648-5816 [Phone]
Exton, PA 19341-1191	610-648-4703 [FAX]

Filing Company Information

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
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Stonebridge Life Insurance Company
187 West Street
Rutland, VT 05701
(410) 685-5500 ext. [Phone]

CoCode: 65021
Group Code: 468
Group Name:
FEIN Number: 03-0164230

State of Domicile: Vermont
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	$50.00	07/06/2010	37764401

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
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Product Name:	*Hospital Indemnity*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/03/2010	08/03/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/19/2010	07/19/2010	SPI ADMSLH	07/22/2010	07/22/2010

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
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Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Disposition

Disposition Date: 08/03/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Supporting Document	Explanation of Variability	Approved-Closed	Yes
Form	Group Accident Indemnity Policy	Approved-Closed	Yes
Form *(revised)*	Group Accident Indemnity Certificate	Approved-Closed	Yes
Form	Group Accident Indemnity Certificate	Replaced	Yes
Form	Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
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Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/19/2010
Submitted Date	07/19/2010
Respond By Date	

Dear Sam Hunt,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Accident Indemnity Policy, SLHAP1000GP (Form)
- Group Accident Indemnity Certificate, SLHAP1000GC.AR (Form)

Comment:

Under the Continuation of coverage provision and with respect to handicapped dependents, it is stated in the policy and certificate that the covered child may continue the coverage if you send a written request for continuation of coverage within 60 days.

ACA 23-86-108(4)(A) states in part that the coverage shall not terminate but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition. Also review our Bulletin 14-81 which states that you may request the insured to submit notice of such incapacity, but you cannot establish a time limit for providing this notice.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
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Product Name:	*Hospital Indemnity*		
Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/22/2010
Submitted Date	07/22/2010

Dear Rosalind Minor,

Comments:
Thank you for your July 19, 2010 letter regarding out-of-state group accident indemnity certificate SLHAP1000GC.AR.

Response 1

Comments: We have revised the certificate by deleting the 60 day requirement for notifying the company that a child coverage should continue beyond the stated termination age. Attached is a copy of the revised certificate SLHAP1000GC.AR. This certificate form will be issued only to Arkansas residents who enroll for coverage under the group policy.

Related Objection 1

Applies To:

- Group Accident Indemnity Policy, SLHAP1000GP (Form)
- Group Accident Indemnity Certificate, SLHAP1000GC.AR (Form)

Comment:

Under the Continuation of coverage provision and with respect to handicapped dependents, it is stated in the policy and certificate that the covered child may continue the coverage if you send a written request for continuation of coverage within 60 days.

ACA 23-86-108(4)(A) states in part that the coverage shall not terminate but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition. Also review our Bulletin 14-81 which states that you may request the insured to submit notice of such incapacity, but you cannot establish a time limit for providing this notice.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
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Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Accident Indemnity Certificate	SLHAP1000GC.AR		Certificate	Revised		48.500	SLHAP1000GC.PDF
Previous Version							
Group Accident Indemnity Certificate	*SLHAP1000GC.AR*		*Certificate*	*Initial*		*48.500*	SLHAP1000GC.PDF

No Rate/Rule Schedule items changed.

Thank you for your consideration of this submission.

Sam Hunt
Manager, Product Filing & Compliance
Stonebridge Life Insurance Company

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: SLHAP1000GP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/03/2010	SLHAP1000GP	Policy/Contract/Fraternal Certificate	Group Accident Indemnity Policy	Initial		43.200	SLHAP1000GP.PDF
Approved-Closed 08/03/2010	SLHAP1000GC.AR	Certificate	Group Accident Indemnity Certificate	Revised	Replaced Form #: Previous Filing #:	48.500	SLHAP1000GC.PDF
Approved-Closed 08/03/2010	SLHAP1000GE.AR	Application/Enrollment Form	Enrollment Form	Initial		41.400	SLHAP1000GE.PDF

Stonebridge Life Insurance Company

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway
Plano, Texas 75075]

Stonebridge Life Insurance Company
(Herein called the Company)

Having issued this Policy to

[XYZ Corporation]
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to persons Insured hereunder, subject to all terms of this Policy.

This Policy is issued in consideration of the payment of premium herein provided, and shall take effect on [JUNE 1, 2010] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR].

This Policy is issued in the State of Missouri, and its terms shall be construed in accordance with the laws of the State of Missouri.

RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The certificate will be treated as if it never existed. No benefits will be paid.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.

Craig D. Vermeer
Secretary

Marilyn Carp
President

Policy No. [XXXXXXXXX]

GROUP ACCIDENT INSURANCE POLICY
PROVIDING ACCIDENT HOSPITAL INDEMNITY BENEFITS
RENEWABLE TO AGE 100

DEFINITIONS

INSURED means each eligible person who has enrolled for coverage as an Insured and whose coverage has become effective.

COVERED PERSON means, for coverage purposes only, the Insured [and the following persons,] provided coverage has become effective[.][:
1. the Insured's lawful spouse; and
2. each of the Insured's unmarried children including step-children, children born to the Insured or legally adopted by the Insured, 25 years of age or younger. (An adopted child is a child who is in the Insured's custody pursuant to an interim court order of adoption or placement of adoption.)]

HOSPITAL means an institution which is a short term acute care general hospital. Its main purpose must be to provide medical care and treatment to injured persons as Resident Patients. It must have facilities on premises for major surgery, medical diagnosis and treatment by or under the supervision of one or more licensed Physicians. It must provide 24 hour a day nursing service by or under the supervision of a registered nurse. It must have organized departments of medicine. It may not include a hospital operating primarily as a rest, convalescent, extended care, chronic or skilled nursing facility; home for the aged; a place for the care and treatment of drug addicts or alcoholics, or a mental institution; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, whether or not such a facility is part of a hospital, as defined herein, or is an entirely separate facility.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being a Resident Patient in a Hospital for Necessary Treatment of an Injury. Such confinement must be prescribed by a Physician.

Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

INTENSIVE CARE UNIT means a specially equipped intensive care unit or cardiac unit located in a segregated section of a Hospital. It provides registered graduate nursing care. It must provide constant audio visual observation for patients who are in critical or serious condition. A daily intensive care fee is charged for room and board. Life saving drugs and equipment must be immediately available or on a standby basis.

RESIDENT PATIENT means a Covered Person who is confined in a Hospital as a registered bed patient and who is provided at least one day of room and board. A Covered Person is considered to be a resident patient each day of Confinement in the Hospital except for the day of discharge; unless a room and board charge is made for that day. This does not include Confinement if it is not for Necessary Treatment or if the Hospital is used primarily as a place for rest, nursing, convalescence or extended care.

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat Injuries. Such person must be providing services within the scope of his or her license. A Physician may not be the Insured or a member of the Insured's Immediate Family.

IMMEDIATE FAMILY means the Insured's spouse, parent, child, brother or sister, or any person living with the Insured.

INJURY means bodily harm caused by an accident which occurs while the Certificate is in force resulting directly and independently of all other causes.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered necessary treatment. No treatment or service or expense in connection therewith, which is experimental in nature, is considered necessary treatment.

The Company may use peer review organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

Services will not be deemed necessary treatment if these criteria are not met.

TRAUMA CENTER means a facility which is licensed to service medical emergencies requiring urgent treatment. It does not refer to a Physician's office or birthing center.

URGENT CARE CENTER means a freestanding facility which is licensed to service medical emergencies requiring urgent treatment. It does not refer to a Physician's office or birthing center.

[**AEGON AFFILIATE** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

[PARTICIPATING GROUP means a group that requests to participate in the insurance trust known as the Policyholder and whose participation has been approved by the Company. The name of such group is shown in the Certificate Schedule of Insurance.]

ELIGIBILITY

Each natural person [AGE 18 THROUGH 64 WHO IS A CREDIT CARDHOLDER (OR THE SPOUSE OF A CREDIT CARDHOLDER AGE 18 THROUGH 64) OF THE POLICYHOLDER] is eligible to become an Insured. Such persons are herein called eligible persons.

[No person shall be covered under more than one Certificate of Insurance under this Policy. Each Certificate may cover only one Insured. If a person is recorded by the Company as an Insured under more than one Certificate, such person shall be deemed to be Insured only under the Certificate which affords that person the greatest amount of coverage. Upon discovery of the duplication of coverage, any premium for the duplicate coverage made by, or on behalf of, the Insured will be refunded.]

In no event will a corporation, partnership, or business entity, other than a natural person, be eligible for insurance.

GUARANTEED RENEWABLE TO AGE 100

Prior to the expiration of the Grace Period of the Insured's Certificate, the payment of the renewal premium is required to keep the Certificate in effect.

The Insured may keep the Certificate in force until the Certificate anniversary date following the Insured's age 100. The Company does not have the right to:

1. cancel the Insured's coverage; or
2. place any restriction on the Insured's coverage while it is in force; or
3. refuse a premium paid on or before the date due or within the Grace Period.

WHEN A PERSON BECOMES INSURED

Each Insured will be issued a Certificate of Insurance which will indicate the coverage, the effective date of coverage, and the persons covered.

[Newborn children are covered immediately from birth. Any required premium must be paid within 31 days. (See the Newborn Children provision.)]

Each eligible person shall become insured on the effective date shown in the Certificate Schedule of Insurance.

WHEN A PERSON'S INSURANCE ENDS

Coverage for each Insured ends on the earliest of:

1. the Certificate anniversary date following the Insured's age 100 (See Continuation of Coverage);
2. the date an Insured dies (See Continuation of Coverage);
3. the last day of the period covered by the Insured's last premium contribution (See Grace Period); or
4. the date each Covered Person ceases to be a Covered Person as defined herein.

The Insured may cancel his or her coverage upon notice to the Company. Notice is deemed to be due or given when made in writing or communicated verbally by telephone, in person, or by any other means acceptable to the Company. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

AMOUNTS OF INSURANCE - SCHEDULE OF INSURANCE

When an eligible person enrolls as an Insured under this Policy, he or she will receive coverage as described in the Coverage section of this Policy. The amounts of insurance for each Covered Person shall be the amount shown in the Certificate Schedule of Insurance issued to each individual Insured.

COVERAGE

A. ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT - The Company will pay the Accident Daily Hospital Confinement Benefit stated in the Certificate Schedule of Insurance beginning with the first day of Confinement for each day a Covered Person is Confined to a Hospital as a Resident Patient for at least 24 hours, provided 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) the Confinement occurs while the Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury.

The Accident Daily Hospital Confinement Benefit will begin with the first day of Confinement and continue for the number of days stated in the Certificate Schedule of Insurance.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of the previously covered Confinement.

Simultaneous Confinement - The Company will pay an additional benefit equal to the Accident Daily Hospital Confinement Benefit stated in the Certificate Schedule of Insurance if the Insured and the Insured's covered spouse are Confined as Resident Patients as the result of an Injury sustained in the same accident and such Confinement begins within 90 days from the date of the accident causing such Injury. This benefit will be payable for each day both the Insured and covered spouse remain Confined at the same time in a Hospital.

B. ACCIDENT DAILY INTENSIVE CARE BENEFIT - The Company will pay the Accident Daily Intensive Care Unit Benefit stated in the Certificate Schedule of Insurance beginning with the first day of Confinement for each day a Covered Person is Confined as a Resident Patient for at least 24 hours to an Intensive Care Unit as a result of a covered Injury provided 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) the Confinement occurs while the Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury.

The Accident Daily Intensive Care Benefit will begin with the first day of Confinement and continue for the number of days stated in the Schedule of Insurance.

This benefit will not be paid in addition to the Accident Daily Hospital Confinement Benefit.

Any transfer from Accident Daily Intensive Care to Accident Daily Hospital Confinement or from Accident Daily Hospital Confinement to Accident Daily Intensive Care will not entitle a Covered Person to receive both benefits at the same time.

C. ACCIDENT DAILY OUTPATIENT BENEFIT: The Company will pay the Accident Daily Outpatient Benefit stated in the Certificate Schedule of Insurance when a Covered Person receives Necessary Treatment of an Injury in a Hospital emergency room, outpatient surgical facility, Trauma Center, Urgent Care Center, or free standing surgical facility. Only one benefit is paid per day up to the maximum number of times stated in the Certificate Schedule of Insurance. The benefit is not paid if the medical treatment or surgery occurs while the Covered Person is Confined as a Resident Patient in a Hospital or Intensive Care Unit Facility.

The Outpatient Surgery must occur within 90 days of the accident causing the Injury.

D. ACCIDENT DAILY PHYSICIAN VISIT BENEFIT: The Company will pay the Accident Daily Physician Visit Benefit stated in the Certificate Schedule of Insurance when a Covered Person visits a Physician for follow-up Necessary Treatment of an Injury. The treatment must be due to an Injury for which an Accident Daily Hospital Confinement Benefit, Accident Daily Intensive Care Unit Benefit, or Accident Daily Outpatient Benefit is payable. The benefit is not paid for Physician visits while the Covered Person is Confined as a Resident Patient in a Hospital or an Intensive Care Unit. Only one benefit is paid per day for the maximum number of visits stated in the Certificate Schedule of Insurance.

E. ACCIDENT AMBULANCE BENEFIT: The Company will pay the Accident Ambulance Benefit stated in the Certificate Schedule of Insurance up to the maximum number of trips stated in the Certificate Schedule of Insurance when a Covered Person is transported in an ambulance to or from a Hospital, Urgent Care Center, or Trauma Center to receive Necessary Treatment of an Injury for which the Accident Daily Hospital Confinement Benefit, Accident Daily Intensive Care Unit Benefit, or Accident Daily Outpatient Benefit is payable.

REDUCTION

All benefits in the Certificate and any riders, if attached, will reduce as shown in the Certificate Schedule of Insurance if, before the date of Injury, [the Insured has][a Covered Person has] attained the age shown in the Certificate Schedule of Insurance.

EXCLUSIONS

No benefit shall be paid for loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (while sane in Missouri and Colorado);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person's blood alcohol level being .08 percent weight by volume or higher;
5. the Covered Person operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, disease, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

[CONTINUATION OF COVERAGE

In the event of the Insured's death, the covered spouse, if any, shall be deemed the Insured. Otherwise, the coverage will terminate on the next renewal date. If a covered spouse ceases to be the spouse of the Insured for reasons other than the Insured's death, the spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Policy shall terminate as of the next monthly renewal date after the covered child's marriage or the date the covered child is no longer a Covered Person as defined herein, whichever occurs first.

An unmarried covered child may continue to be covered upon reaching the limiting age as specified in the Covered Person definition, if:

1. the covered child is incapable of self-sustaining employment by reason of mental or physical handicap; and
2. dependent upon the Insured for support and maintenance; and
3. the Insured sends us a written request for continuation of coverage within 60 days; and
4. the Insured provides proof of incapacity as requested but no more than once annually; and
5. the Insured pay the premium for adult benefits, if required.

Coverage may be extended for any covered child who is a full-time student at a postsecondary educational institution and who takes a Medically Necessary Leave of Absence until the earlier of one year or the date coverage would otherwise terminate under the contract terms. The Insured must notify the Company and provide proof of Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is defined as a leave of absence from a postsecondary educational institution or a change in enrollment of the covered child that:

1. begins while the covered child is suffering from a serious illness;
2. is medically necessary; and
3. causes the covered child to lose student status for the purposes of coverage under the Certificate.]

[CONVERSION

The covered child or spouse whose coverage ceases may apply for his or her own certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new certificate will be issued:

1. on the Company's form at that time with benefits most like but not greater than those of the current Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of Coverage under the new certificate will be the same as the effective date of the conversion. The Company will not pay under the new certificate for any loss for which benefits have been paid under the current Certificate.]

[NEWBORN CHILDREN

If the Insured's spouse or any children are already covered under the Certificate and a child is born to the Insured, the benefit amount for the newborn child will be the same as for other children. If no other child is covered under the Certificate, the benefit will be the amount which would have been issued to children as of the effective date of the Certificate.

If neither the Insured's spouse nor another child is covered under the Certificate and if the Insured wishes to add child coverage, the Insured must notify the Company of the child's birth within 31 days of the birth and pay the required additional premium. The child's benefit will be the amount which would have been issued to children as of the effective date of the Certificate. After the initial 31 days, the child will not be covered unless the required additional premium is paid in accordance with the provisions of the Certificate.]

PREMIUM

PAYMENT OF PREMIUM

The premium rate for each Insured is included on the attached rate sheet.

All premiums due by the terms of this Policy shall be paid to the Company Administrative Office on or prior to the day they are due.

[For the first [two][three] month[s] of coverage, the premium will be paid by the [Policyholder/Participating Group].]

[After the first [two][three] month[s]], [the Insured is required to contribute 100 percent of the premium payable for the Certificate.].

[If no initial premium is requested by the Company with the enrollment form, the Insured will have 21 days from the Effective Date shown in the Certificate Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any Injury.]

If at any time the [Participating Group][Policyholder] refuses to accept such contributions and pay the premium for an Insured, the Insured may pay such premium directly to the Company's Administrative Office on or prior to the day it is due.

PREMIUM CHANGES

All renewal premiums will be based on the Company's rates in effect for each Certificate on the date such premiums are due.

The Company has the right to change the premium rates on any date. The new rates will be based on the ages of the Covered Persons on the dates they became insured. The Company will provide written notice at least 31 days before the date of change.

The premium rates may also be changed at any time the terms of the Group Policy are changed.

The Company will not increase an Insured's rates in the first Certificate year of coverage. After that, rates will not increase more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

The premium amount due may change when a Covered Person is added to or dropped from coverage or when benefits under the Certificate change. Any additional coverage is subject to the Company's acceptance of the enrollment form, if required, and payment of any additional required premium.

GRACE PERIOD

If a premium is not paid when due, the insurance shall be in default. The Company will allow a 31 day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate effective the last day of the period covered by the last premium contribution.

REINSTATEMENT

The Insured's Certificate will lapse if the Insured does not pay his or her premium before the end of the Grace Period. If the Company later accepts a premium and does not require an application for reinstatement, that payment will put the Certificate back in force. If the Company requires an application for reinstatement, the Certificate will be put back in force when the Company approves it. If the Company does not approve it, the Certificate will be put back in force on the 45th day after the date of application for reinstatement, unless the Company gives the Insured prior written notice of its disapproval.

The reinstated Certificate covers only loss due to an Injury caused by an accident that occurs after the date of reinstatement. In all other respects, the Company and the Insured have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, the Company accepts a premium for any period when coverage would not normally have been in effect, then the Company's liability for such period shall be a refund, upon request, of all premiums paid for such period.

WHEN THERE IS A CLAIM

NOTICE OF CLAIM

Written Notice of Claim must be given to the Company within 30 days after any loss covered under this Policy occurs or as soon as possible thereafter. The notice should include the Insured's name and Certificate number as shown on the Certificate Schedule of Insurance. Notice should be mailed to the Company at its Administrative Office.

CLAIM FORMS

When the Company receives the Notice of Claim, the Company will send the claimant forms for filing Proof of Loss. If the Company does not send the forms within 15 days, the claimant shall be deemed to have complied with the requirements of the Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

PROOF OF LOSS

Written proof of loss must be given to the Company within 90 days after the date of the Loss or as soon as possible thereafter. Failure to produce proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within this time period. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

The Company will pay all benefits covered by this Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

PAYMENT OF CLAIMS

All benefits are payable to the Insured, if living. Unless otherwise specified, any other benefit unpaid at the Insured's death will be paid as follows:

1. to the Insured's living lawful spouse; or if the Insured does not have one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of death. Except in the case of a legal adoption, lawful children and parents do not mean "step" children or parents.

PHYSICAL EXAM AND AUTOPSY

At its own expense, the Company shall have the right to examine a Covered Person when and as often as is reasonable while a claim is pending. The Company may also have an autopsy done where it is not prohibited by law.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy is issued in consideration of the application and payment of the premium. Insureds' Certificates are furnished in accordance with and subject to the terms of the Policy. Certificates are not part of the Policy, but are evidence of the insurance provided under this Policy. This Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the Policyholder and the Company in this manner will be binding on all persons insured. Certificate anniversaries are measured from the Certificate effective date.

INCONTESTABILITY

The Company cannot contest an Insured's Certificate except for fraud or for not paying premiums.

INFORMATION TO BE FURNISHED

The Policyholder shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the Policyholder or in possession of the Policyholder which relates to this Policy.

CLERICAL ERROR

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

INSURED'S CERTIFICATE

The Company will issue an individual Certificate to each Insured. The Certificate will describe the insurance coverage and state to whom the benefits will be paid.

LEGAL ACTIONS

No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

[OTHER INSURANCE

If a Covered Person is insured under more than one accident hospital indemnity policy or certificate in effect with the Company or any Aegon Affiliate at any one time, the Company's maximum liability is limited to [a total of [5-20] certificates and policies with all Aegon Affiliates.] [[or] a total of [$25,000 - 400,000] for any one accident from all Aegon Affiliates]. Upon discovery of duplication in excess of the Company's maximum liability, all premiums paid will be refunded for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to the Insured or to the Insured's beneficiary.]

Stonebridge Life Insurance Company

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075]

CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No.[25XXX GCXXX] to [XYZ Corporation] (herein called Policyholder) which makes available accident medical indemnity insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return this Certificate of Insurance within [30/60/90] days after its receipt to us at our Administrative Office. If the Certificate is returned, insurance under the Policy shall be deemed void from the Certificate's Effective Date. Any premium you have paid will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

[This Certificate supersedes any Certificate previously issued to you under the Policy. You and any Covered Person may qualify under one Certificate only. If any person is insured under more than one Certificate, we will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any duplicated payments which may have been made on behalf of that person.]

GUARANTEED RENEWABLE TO AGE 100

Prior to the expiration of the Grace Period of your Certificate, the payment of the renewal premium is required to keep the Certificate in effect.

You may keep the Certificate in force until the Certificate anniversary date following your age 100. We do not have the right to:
1. cancel your coverage; or
2. place any restriction on your coverage while it is in force; or
3. refuse a premium paid on or before the date due or within the Grace Period.

This Certificate is signed for Stonebridge Life Insurance Company by its Secretary and its President.

Craig D. Vermie
Secretary

Marilyn Cerp
President

GROUP ACCIDENT INSURANCE
PROVIDING ACCIDENT HOSPITAL INDEMNITY BENEFITS
RENEWABLE TO AGE 100

Stonebridge Life Insurance Company

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25517 GCXXX] to [XYZ Corporation]

[PARTICIPATING GROUP NUMBER: XXXXXX

PARTICIPATING GROUP: XXXXXXXXX]

CERTIFICATE NUMBER: [82A1000000]

EFFECTIVE DATE: [6-01-2010]

INSURED: [JOHN DOE
221 ANYSTREET
APARTMENT 1231
ANYTOWN, USA 12345]

[INITIAL PREMIUM:] [$1.00]
MONTHLY PREMIUM: [$XX.XX]

[FAMILY COVERAGE]: [YES]

[PREMIUM CONTRIBUTION]: [100% AFTER THE FIRST [1][2][3] MONTHS]

	BENEFIT	AMOUNT [INSURED]	[SPOUSE]	[EACH CHILD]
A.	ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT	[$ 100-$500] [PER DAY]	[$ 100-$500] [PER DAY]	[$ 50-$250] [PER DAY]
	[MAXIMUM NUMBER OF DAYS [PER COVERED PERSON]]:	[[60-365]DAYS]		
B.	ACCIDENT DAILY INTENSIVE CARE UNIT BENEFIT	[$ 200-$1000] [PER DAY]	[$ 200-$1000] [PER DAY]	[$ 100-$125] [PER DAY]
	[MAXIMUM NUMBER OF DAYS [PER COVERED PERSON]]:	[[60-365] DAYS]		
C.	ACCIDENT DAILY OUTPATIENT BENEFIT	[$ 50-$250] [PER DAY]	[$ 50-$250] [PER DAY]	[$ 25-$125] [PER DAY]
	[MAXIMUM NUMBER OF TIMES PAID EACH CALENDAR YEAR [PER COVERED PERSON]]:	[3-10]		
D.	ACCIDENT DAILY PHYSICIAN VISIT BENEFIT	[$ 20-$100] [PER DAY]	[$ 20-$100] [PER DAY]	[$ 10-$50] [PER DAY]
	[MAXIMUM NUMBER OF TIMES PAID EACH CALENDAR YEAR [PER COVERED PERSON]]:	[3-10]		
E.	ACCIDENT AMBULANCE BENEFIT	[$ 50-$250] [PER TRIP]	[$ 50-$250] [PER TRIP]	[$ 25-$125] [PER TRIP]
	[MAXIMUM NUMBER OF TRIPS PAID EACH CALENDAR YEAR [PER COVERED PERSON]]:	[3-10]		

BENEFITS FOR ALL COVERED PERSONS WILL REDUCE BY ONE-HALF (50%) OF THE AMOUNTS LISTED ABOVE IF, BEFORE THE DATE OF INJURY, A COVERED PERSON ATTAINS AGE 80.

DEFINITIONS

INSURED (herein called "you," "your," or "yours") means you, the insured named in the Schedule of Insurance, provided coverage has become effective.

COVERED PERSON means, for coverage purposes only, you [and the following persons,] provided coverage has become effective[.][:

1. your lawful spouse; and
2. each of your unmarried children including step-children, children born to you or legally adopted by you, 25 years of age or younger. (An adopted child is a child who is in your custody pursuant to an interim court order of adoption or placement of adoption or newborns to be adopted if the petition fro adoption is filed within 60 days after the birth.)]

HOSPITAL means an institution which is a short term acute care general hospital. Its main purpose must be to provide medical care and treatment to injured persons as Resident Patients. It must have facilities on premises for major surgery, medical diagnosis and treatment by or under the supervision of one or more licensed Physicians. It must provide 24 hour a day nursing service by or under the supervision of a registered nurse. It must have organized departments of medicine. It may not include a hospital operating primarily as a rest, convalescent, extended care, chronic or skilled nursing facility; home for the aged; a place for the care and treatment of drug addicts or alcoholics, or a mental institution; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, whether or not such a facility is part of a hospital, as defined herein, or is an entirely separate facility.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being a Resident Patient in a Hospital for Necessary Treatment of an Injury. Such confinement must be prescribed by a Physician.

Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

INTENSIVE CARE UNIT means a specially equipped intensive care unit or cardiac unit located in a segregated section of a Hospital. It provides registered graduate nursing care. It must provide constant audio visual observation for patients who are in critical or serious condition. A daily intensive care fee is charged for room and board. Life saving drugs and equipment must be immediately available or on a standby basis.

RESIDENT PATIENT means a Covered Person who is confined in a Hospital as a registered bed patient and who is provided at least one day of room and board. A Covered Person is considered to be a resident patient each day of Confinement in the Hospital except for the day of discharge; unless a room and board charge is made for that day. This does not include Confinement if it is not for Necessary Treatment or if the Hospital is used primarily as a place for rest, nursing, convalescence or extended care.

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat Injuries. Such person must be providing services within the scope of his or her license. A physician may not be you or a member of your Immediate Family.

IMMEDIATE FAMILY means your spouse, parent, child, brother or sister, or any person living with you.

INJURY means bodily harm caused by an accident which occurs while this Certificate is in force resulting directly and independently of all other causes.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any Confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered necessary treatment. No treatment or service in connection therewith, which is experimental in nature, is considered necessary treatment.

We may use peer review organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

Services will not be deemed necessary treatment if these criteria are not met.

TRAUMA CENTER means a facility which is licensed to service medical emergencies requiring urgent treatment. It does not refer to a Physician's office or birthing center.

URGENT CARE CENTER means a freestanding facility which is licensed to service medical emergencies requiring urgent treatment. It does not refer to a Physician's office or birthing center.

[**AEGON AFFILIATE** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

[**PARTICIPATING GROU**P is the organization named in the Schedule of Insurance.]

WHEN YOUR INSURANCE BEGINS

Each eligible person will become insured under this Certificate at 12:01 a.m., Standard Time on the Certificate Effective Date following acceptance by us of the enrollment form, if required, and upon receipt of the first premium [before/within 21 days of] the Certificate Effective Date. The premium and the Effective Date of Coverage are shown in the Certificate Schedule of Insurance.

[Newborn children are covered immediately from birth. Any required premium must be paid within 31 days. (See the Newborn Children provision.)]

Issuance of a Certificate is not a waiver of any of the above conditions.

WHEN YOUR INSURANCE ENDS

Coverage ends on the earliest of:

1. the Certificate anniversary date following your age 100 (See Continuation of Coverage);
2. the date you die (See Continuation of Coverage);
3. the last day of the period covered by your last premium contribution (See Grace Period); or
4. the date each Covered Person ceases to be a Covered Person as defined herein.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

COVERAGE

A. ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT - We will pay the Accident Daily Hospital Confinement Benefit stated in the Schedule of Insurance beginning with the first day of Confinement for each day a Covered Person is Confined to a Hospital as a Resident Patient for at least 24 hours, provided 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) the Confinement occurs while this Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury.

The Accident Daily Hospital Confinement Benefit will begin with the first day of Confinement and continue for the number of days stated in the Schedule of Insurance.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of the previously covered Confinement.

Simultaneous Confinement - We will pay an additional benefit equal to the Accident Daily Hospital Confinement Benefit stated in the Schedule of Insurance if you and your covered spouse are Confined as Resident Patients as the result of an Injury sustained in the same accident and such Confinement begins within 90 days from the date of the accident causing such Injury. This benefit will be payable for each day both you and your covered spouse remain Confined at the same time in a Hospital.

B. ACCIDENT DAILY INTENSIVE CARE BENEFIT - We will pay the Accident Daily Intensive Care Unit Benefit stated in the Schedule of Insurance beginning with the first day of Confinement for each day a Covered Person is Confined as a Resident Patient for at least 24 hours to an Intensive Care Unit as a result of a covered Injury provided 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) the Confinement occurs while this Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury.

The Accident Daily Intensive Care Benefit will begin with the first day of Confinement and continue for the number of days stated in the Schedule of Insurance.

This benefit will not be paid in addition to the Accident Daily Hospital Confinement Benefit.

Any transfer from Accident Daily Intensive Care to Accident Daily Hospital Confinement or from Accident Daily Hospital Confinement to Accident Daily Intensive Care will not entitle a Covered Person to receive both benefits at the same time.

C. ACCIDENT DAILY OUTPATIENT BENEFIT: We will pay the Accident Daily Outpatient Benefit stated in the Schedule of Insurance when a Covered Person receives Necessary Treatment of an Injury in a Hospital emergency room, outpatient surgical facility, Trauma Center, Urgent Care Center, or free standing surgical facility. Only one benefit is paid per day up to the maximum number of times stated in the Schedule of Insurance. This benefit is not paid if the medical treatment or surgery occurs while the Covered Person is Confined as a Resident Patient in a Hospital or Intensive Care Unit Facility.

The Outpatient Surgery must occur within 90 days of the accident causing the Injury.

D. ACCIDENT DAILY PHYSICIAN VISIT BENEFIT: We will pay the Accident Daily Physician Visit Benefit stated in the Schedule of Insurance when a Covered Person visits a Physician for follow-up Necessary Treatment of an Injury. The treatment must be due to an Injury for which an Accident Daily Hospital Confinement Benefit, Accident Daily Intensive Care Unit Benefit, or Accident Daily Outpatient Benefit is payable. The benefit is not paid for Physician visits while the Covered Person is Confined as a Resident Patient in a Hospital or an Intensive Care Unit. Only one benefit is paid per day for the maximum number of visits stated in the Schedule of Insurance.

E. ACCIDENT AMBULANCE BENEFIT: We will pay the Accident Ambulance Benefit stated in the Schedule of Insurance up to the maximum number of trips stated in the Schedule of Insurance when a Covered Person is transported in an ambulance to or from a Hospital, Urgent Care Center, or Trauma Center to receive Necessary Treatment of an Injury for which the Accident Daily Hospital Confinement Benefit, Accident Daily Intensive Care Unit Benefit, or Accident Daily Outpatient Benefit is payable.

REDUCTION

All benefits in this Certificate and any riders, if attached, will reduce as shown in the Schedule of Insurance if, before the date of Injury, [you have][a Covered Person has] attained the age shown in the Schedule of Insurance.

EXCLUSIONS

No benefit shall be paid for Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (while sane in Missouri and Colorado);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person’s blood alcohol level being .08 percent weight by volume or higher;
5. the Covered Person’s operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person’s committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, disease, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

[CONTINUATION OF COVERAGE

In the event of your death, your covered spouse, if any, shall be deemed the Insured. Otherwise, the coverage will terminate on the next renewal date. If your spouse ceases to be your spouse for reasons other than your death, your spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Certificate shall terminate as of the next monthly renewal date after the covered child's marriage or the date the covered child is no longer a Covered Person as defined herein, whichever occurs first.

An unmarried covered child may continue to be covered upon reaching the limiting age as specified in the Covered Person definition, if:

1. the covered child is incapable of self-sustaining employment by reason of mental or physical handicap; and
2. dependent upon you for support and maintenance; and
3. you send us a written request for continuation of coverage; and
4. you provide proof of incapacity as requested but no more than once annually; and
5. you pay the premium for adult benefits, if required.

Coverage may be extended for any covered child who is a full-time student at a postsecondary educational institution and who takes a Medically Necessary Leave of Absence until the earlier of one year or the date coverage would otherwise terminate under the contract terms. You must notify us and provide proof of Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is defined as a leave of absence from a postsecondary educational institution or a change in enrollment of the covered child that:

1. begins while the covered child is suffering from a serious illness;
2. is medically necessary; and
3. causes the covered child to lose student status for the purposes of coverage under this Certificate.]

[CONVERSION

The covered child or spouse whose coverage ceases may apply for his or her own certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new certificate will be issued:

1. on a form at that time with benefits most like but not greater than those of this Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of coverage under the new certificate will be the same as the effective date of the conversion. We will not pay under the new certificate for any Injury for which benefits have been paid under this Certificate.]

[NEWBORN CHILDREN

If your spouse or any children are already covered under this Certificate and a child is born to you, the benefit amount for the newborn child will be the same as for other children. If no other child is covered under this Certificate, the benefit will be the amount which would have been issued to children as of the effective date of this Certificate.

If neither your spouse nor another child is covered under this Certificate and if you wish to add child coverage, you must notify us of the child's birth within 31 days of the birth and pay the required additional premium. The child's benefit will be the amount which would have been issued to children as of the effective date of this Certificate. After the initial 31 days, the child will not be covered unless the required additional premium is paid in accordance with the provisions of this Certificate.]

PREMIUM

PAYMENT OF PREMIUM

All premiums due by the terms of the Policy shall be paid to our Administrative Office on or prior to the day they are due.

[For the first [two][three] month[s] of coverage, the premium will be paid by the [Policyholder/Participating Group].]

[After the first [two][three] month[s]], [you are required to contribute 100 percent of the premium payable for this Certificate.].

[If no initial premium is requested by us with your enrollment form, you shall have 21 days from the Effective Date shown in the Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any Injury.]

If at any time the [Participating Group][Policyholder] refuses to accept such contributions and pay the premium for you, you may pay such premium directly to our Administrative Office on or prior to the day it is due.

PREMIUM CHANGES

All renewal premiums will be based on our rates in effect for this Certificate on the date such premiums are due.

We have the right to change the premium rates on any date. The new rates will be based on the ages of the Covered Persons on the dates they became insured. We will provide written notice at least 31 days before the date of change.

The premium rates may also be changed at any time the terms of the Group Policy are changed.

We will not increase your rates in the first Certificate year of coverage. After that, rates will not increase more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

The premium amount due may change when a Covered Person is added to or dropped from coverage or when benefits under this Certificate change. Any additional coverage is subject to our acceptance of the enrollment form, if required, and payment of any additional required premium.

GRACE PERIOD

If a premium is not paid when due, the insurance shall be in default. We will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate, effective the last day of the period covered by your last premium contribution.

REINSTATEMENT

Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45th day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only provides benefits for an Injury caused by an accident that occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

WHEN THERE IS A CLAIM

NOTICE OF CLAIM

Written notice of claim must be given to us within 30 days after any loss covered under this Certificate occurs or as soon as possible thereafter. The notice should include your name and Certificate Number as shown in the Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

CLAIM FORMS

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in this Certificate for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the date of the Loss or as soon as possible thereafter. Failure to produce proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within this time period. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

We will pay all benefits covered by this Certificate as soon as we receive proper written Proof of Loss sufficient to determine liability.

PAYMENT OF CLAIMS

All benefits are payable to you, if living. Unless you specify otherwise, any other benefit unpaid at your death will be paid as follows:

1. to your living lawful spouse; or if you do not have one,
2. in equal shares to your living lawful children; or if there are none,
3. in equal shares to your living lawful parents; or if there are none,
4. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of a legal adoption, lawful children and parents do not mean “step” children or parents.

PHYSICAL EXAM AND AUTOPSY

At our expense, we shall have the right to examine a Covered Person when and as often as is reasonable while a claim is pending. We may also have an autopsy done where it is not prohibited by law.

GENERAL PROVISIONS

ENTIRE CONTRACT

Your Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

INCONTESTABILITY

We cannot contest this Certificate except for fraud or for not paying premiums.

LEGAL ACTIONS

No action can be brought to recover on this Certificate for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

[OTHER INSURANCE

If a Covered Person is insured under more than one accident hospital indemnity policy or certificate in effect with us or any Aegon Affiliate at any one time, our maximum liability is limited to [a total of [5-20] certificates and policies with all Aegon Affiliates.] [[or] a total of [$25,000 - 400,000] for any one accident from all Aegon Affiliates]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to you or to your beneficiary.]

[Variable Logo] ENROLLMENT FORM

Underwritten by Stonebridge Life Insurance Company
Home Office: Rutland, Vermont
Administrative Offices: [2700 West Plano Parkway, Plano, TX 75075]

[John Doe]
[Jane Doe (if covered)]
[123 Main Street]
[Apartment #X]
[Columbia, SC XXXXX]

[Please respond by: [Month XX, 2010]]

[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

[HOW TO ACTIVATE COVERAGE]

1. [Select amount of coverage you want]
2. [Complete your information]
3. [Sign, date and return entire form]

1. Personal Information *Please complete ALL questions.*

4 Customer Information

Name__[_____]_____[_____]_____[_____]_____
FIRST MIDDLE LAST

Address___[_____]_____ Apt. [_____]_

City_[_____]_____ State___[_____]__Zip__[_____]__

Home Phone ([_____]_)[_____]_Date of Birth[_____|_____|_____] Sex: o Male o Female
AREA CODE MONTH DAY YEAR

[Email address: _____]

4 [Spouse Information (if enrolling)]

Name_____
FIRST MIDDLE LAST

[Date of Birth_____|_____|_____ Sex: o Male o Female]
MONTH DAY YEAR

2. Choose the Benefits You Want *Select one option in each section.*

[The monthly costs for the first [30] days of coverage will be paid for by [ABC Bank]]

4 AMOUNT OF ACCIDENT COVERAGE [YOU WANT]: [o $100 per day] [o $200 per day] [o $300 per day]

4 Check the plan you want:

[o Individual Only] [$9.95]

[o Family Protection] [$19.90]

or

	Individual Only	Family Protection
[Basic][Bronze][$100 per day]	• $[4.95]	• $[9.95]
[Enhanced][Silver][$200 per day]	• $[9.95]	• $[19.90]
[Deluxe][Gold][$300 per day]	• $[14.95]	• $[29.90]
[Premier][Platinum][$400 per day]	• $[19.95]	• $[39.90]

[*A [50¢] administrative fee will be added for each automatic account billing.]

[Bar Code for Scanning Purposes]

4 Check here if you are eligible to receive Medicare benefits: o You [o Spouse (if enrolling)]

[Complete and sign][Please complete:]

4. Payment Information [Deduct from my Bank/Credit Union Checking Account (Your payment is made directly

a o Bill me. Your first [month's] premium must be received before the effective date.] [I have enclosed my first month's premium.]

b o [Deduct from my Bank/Credit Union Checking Account (Your payment is made directly through your bank or credit union share draft account.)
IMPORTANT: Write "VOID" on a blank check from this account and send it with this application.]

c o Charge my Credit Card (check one): o Visa o Master Card o Discover (Your payments are automatically billed to your VISA, MasterCard, or Discover credit card account and shown as part of your statement.) (Credit Card payment not available in AL, NH, NC)
Account #_____-_____-_____-_____ Expiration Date _____|_____
Month Year

Subject to my account's rules, charge or deduct my premiums (including future changes to my insurance) by electronic or other method from the credit card or checking account I have selected above. I can cancel this payment method at any time by writing to you.

5. Read and Sign [— *Then return in the postage paid envelope provided.]*

I understand that no coverage is in effect until a Certificate is issued and the first premium is received before the Effective Date and during my lifetime. I also understand that only accidental bodily injuries sustained on or after my Certificate Effective Date will be covered. I understand that subject to the company's maximum coverage limit, I can have more than one policy/certificate providing the same or similar coverage. [I have read my state's fraud notice on the back of this enrollment form.]

[SIGN, DATE AND MAIL] I [enroll in][apply for] the [[Group] [Hospital] [Accident][Accident Care][5 Way Medical] [Insurance] [Plan] underwritten by Stonebridge Life Insurance Company. [By signing below, I authorize [ABC Bank] to provide the Insurance Company with my [ABC Bank] checking account number and any other information required to activate my coverage.]][After the first 30 days,] I authorize my premium to be [deducted] [processed][billed] [quarterly] monthly] and [electronically] remitted to the Insurance Company [from] [through] my [ABC Bank][credit card] [checking] [savings] [share] [share draft] [Credit Union] account.][I authorize my lending institution to collect the premium with my monthly mortgage payment [after my first [2 months] of no-cost coverage].]] [I hereby consent to the release of my [ABC Bank] checking account number to third parties for the purpose of billing and processing in connection with my request for Coverage.] [If I sign and return this form without selecting a coverage amount I understand that I will be automatically enrolled for Individual Coverage.] [This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage.] Coverage begins on the Effective Date stated on the Certificate of Insurance [provided the first premium is paid]. [Note: Coverage amounts begin to decrease at age [80].] [*A [$0.50] administrative fee will be added for each automatic account billing.] I acknowledge that I have received, read and understand the insurance disclosures [on the reverse side of this form][and][below].

[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [ABC Bank], to activate my coverage.]

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

X____ [_____] [_____] ____
YOUR SIGNATURE DATE
[Customer's] Signature (Required) (Required)

[DO NOT SEND MONEY. COMPLETE, SIGN AND MAIL THIS FORM IN THE [POSTAGE-PAID] ENVELOPE PROVIDED.]

[INSURANCE DISCLOSURES]

[This insurance product is not a deposit; not FDIC insured; not insured by any federal government agency; and is not guaranteed by the financial institution/affiliate.]

[The insurance product is: not FDIC or other government agency insured; not a deposit in, obligation of, guaranteed or underwritten by any bank or bank affiliate; not a condition of any banking service.]

[FDIC for all states except GA:
Insurance is not insured by the FDIC, any other agency of the United States, the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; and is not issued, guaranteed, or underwritten by the bank, its affiliates or the FDIC.

FDIC statement for GA:
Insurance is not insured by the FDIC, any other agency of the United States, or the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; is not guaranteed or underwritten by the bank or affiliates; and is not a condition to the provision or term of any banking service or activity.]

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
Company Tracking Number:	*AR0055900004*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Hospital Indemnity*		
Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/03/2010

Bypass Reason: Enrollment Form SLHAP1000GE.AR attached to Form Tab.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/03/2010

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	08/03/2010

Comments:

NAIC Transmittal Document

Attachment:

AR - NAIC TRANSMITTAL DOCUMENT.PDF

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	08/03/2010

Comments:

NAIC Form Filing Attachment

Attachment:

AR - NAIC FORM FILING ATTACHMENT.PDF

		Item Status:	Status

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
Company Tracking Number:	*AR0055900004*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Hospital Indemnity*		
Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Satisfied - Item: Explanation of Variability — Approved-Closed — **Date:** 08/03/2010

Comments:

Explanation of Variables

Attachment:

Explanation of Variables.PDF

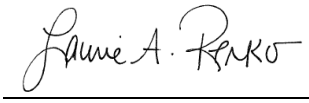
STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Stonebridge Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SLHAP1000GP	43.3
SLHAP1000GC.AR	48.8
SLHAP1000GE.AR	41.4

Signed: 

Name: Laurie A. Renko

Title: Vice President

Date: July 6, 2010

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Stonebridge Life Insurance Company 187 West Street Rutland VT 05701		VT		468	65021	03-0164230	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Sam Hunt 300 Eagleview Boulevard Exton PA 19341-1191		800-678-5901	610-648-4703	shunt@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	AR0055900004
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☒ Small and Large ☐ Employer ☐ Association ☐ Blanket ☒ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H02G Group Health - Accident Only
10.	**Product Coding Matrix Filing Code**	H02G.000 Health - Accident Only
11.	**Submitted Documents**	☐ **FORMS** ☒ Policy ☐ Outline of Coverage ☒ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☒ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	July 6, 2010
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	N/A
15.	**Filing Description:**	

Stonebridge Life Insurance Company
NAIC: 0468-65021
FEIN: 03-0164230
RE: SLHAP1000GP Group Accident Indemnity Policy
SLHAP1000GC.AR Group Accident Indemnity Certicate
SLHAP1000GE.AR Enrollment Form
Actuarial Memorandum

Enclosed for your review and approval is out-of-state group hospital indemnity certificate SLHAP1000GC.AR. This form is new and is not intended to replace any previously approved form. The form is completed in "John Doe" fashion. Variable information is printed and bracketed in red.

The group policy, form SLHAP1000GP, was approved by the Missouri Department of Insurance on May 5, 2010. The controlling group policy is contemplated for issue to various discretionary groups that are situsedin Missouri. The policy will initially be issued to National Financial Institutions Group Insurance Trust which is a participating group trust comprised of banks and financial institutions.

Group Certificate SLHAP1000GC,AR provides a benefit for daily hospital confinement due to an accident resulting in an injury. Additional indemnity benefits include Accident Daily Intensive Care Unit Benefit that pays if the covered person is confined to an intensive care unit; an Accident Daily Outpatient Benefit that pays for necessary treatment in a hospital emergency room or other outpatient facility; an accident daily physician visit benefit that pays for physician visits for follow up treatment after an injury and an Accident Ambulance Benefit which pays for transportation to or from a hospital facility.

Coverage is guaranteed issued and guaranteed renewable to age 100.

Enclosed is an Actuarial Memorandum in support of this product.

The company has reviewed the enclosed forms and certifies that each form submitted meets the provisions of rule 19 as well as all applicable re1quirements of the Arkansas Insurance Department.

We request approval of the submitted forms in various dimensions, format, shading and colors. No dimension/format/shading/color change would produce unacceptable print. The referenced form may be used in other media formats including translations into (Spanish, Chinese, Korean, Vietnamese, Polish, etc) and in such case, we certify the content will not change.

This product will be mass marketed by direct mail, telemarketing and possibly on the Internet through our website.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Sam Hunt Title Manager, Product Filing & Compliance

Signature  Date 7/6/2010

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	AR0055900004
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Group Accident Indemnity Policy	SLHAP1000GP	☒ Initial ☐ Revised ☐ Other _____	
02	Group Accident Indemnity Certificate	SLHAP1000GC.AR	☒ Initial ☐ Revised ☐ Other _____	
03	Enrollment Form	SLHAP1000GE.AR	☒ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	

Explanation of Variables

The following is an explanation of the variables indicated in the submitted forms for **National Financial Institution Group Insurance Trust.**

GROUP CERTIFICATE SLHAP1000GC.TX

PAGE 1
COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

a) 2700 West Plano Parkway
Plano, Texas 75075-8200

b) 520 Park Avenue
Baltimore, Maryland 21201

c) Valley Forge, Pennsylvania 19493

Policy number and Policyholder name are specific to each policy.

The Right to Examine period may be 30, 60 or 90 days as determined by the policyholder.

PAGE 2

SCHEDULE PAGE: Policy number and Policyholder name: Policy number and Policyholder name are specific to each group policyholder. Participating group and participating group number will be included when the policy is issued to a participating group trust. National Financial Institution Group Insurance Trust is the participating group to which the master policy is issued for this filing.

Personal data on the Schedule of Insurance is variable as it pertains to the Insured, and the amount of coverage purchased.

Initial Premium: This language will appear when the first premium is a deviation from the monthly premium. The deviated premium will be used by this policyholder.

Premium Contribution: This language will appear when the initial premium is paid by the Group Policyholder or the Participating Group. The number of months will be 1, 2 or 3 and will reflect the period covered by the initial premium.

Benefit amounts will be determined by the group policyholder or participating group. Maximum number of days, times and trips will be for each covered person or a maximum per calendar year. This will be whatever the policyholder/participating group chooses to offer to the insureds.

PAGE 4

DEFINITIONS:

Participating Group will be included when the policy is issued to a participating group. National Financial Institution Trust is a participating trust.

PAGE 6

PAYMENT OF PREMIUM: The term Participating Group is used when the coverage is issued to a group trust with participants in the trust.

Number of months and premium: Based on the policyholder/participating group information. The second paragraph regarding initial premium information will be included when the Group Policyholder/participating group pays the initial premium. It will be deleted when the Insured pays the initial premium.

[For the first [two][three] month[s] of coverage, the premium will be paid by the [Policyholder / Participating Group.] – This language will appear when the initial premium is paid by the Group Policyholder. The number of months will be 1, 2 or 3 and will reflect the period covered by the initial premium.

Third paragraph, first sentence - [after the first [two][three] month[s]] – This language will appear when the initial premium is paid by the Group Policyholder/participating group. The number of months will be 1, 2 or 3 and will reflect the period covered by the initial premium.

MASTER POLICY SLHAP1000GP

PAGE 1

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

d) 2700 West Plano Parkway
Plano, Texas 75075-8200

e) 520 Park Avenue
Baltimore, Maryland 21201

f) Valley Forge, Pennsylvania 19493

Policyholder name, effective date and Policy number are specific to each policy.

The Right to Examine period may be 30, 60 or 90 days as determined by the policyholder/participating group.

PAGE 2

DEFINITIONS:

PAGE 3

Participating Group will be included when the policy is issued to a participating group. National Financial Institution Group Insurance Trust is a participating group.

ELIGIBILITY:

Defines the group and will vary based on the group the Policyholder is insuring.

Page 7

Number of months and premium: Based on the policyholder information. The second paragraph regarding Initial premium information will be included when the Group Policyholder pays the initial premium. It will be deleted when the Insured pays the initial premium.

[For the first [two][three] month[s] of coverage, the premium will be paid by the [Policyholder / Participating Group.] – This language will appear when the initial premium is paid by the Group Policyholder. The number of months will be 1, 2 or 3 and will reflect the period covered by the initial premium.

Third paragraph, first sentence - [after the first [two][three] month[s]] – This language will appear when the initial premium is paid by the Group Policyholder/Participating Group. The number of months will be 1, 2 or 3 and will reflect the period covered by the initial premium.

ENROLLMENT FORM SLHAP1000GE.TX

Language will vary based on the offer by the policyholder who will choose whether spouse coverage is offered, options offered; customer information requested; beneficiary information requested. Below is an explanation of the bracketed portions of the form.

Variable Data	Explanation
[2700 West Plano Parkway, Plano, Texas 75075-8200] [520 Park Avenue, Baltimore, Maryland 21201] [Valley Forge, Pennsylvania 19493]	Stonebridge Life Insurance Company has several administrative office locations. This product may be administered from one of three locations.
[John Doe] [Jane Doe (if covered)] [123 Main Street] [Apartment #X] [Columbia, SC XXXXX]	Customer name and address will appear here when it is preprinted on the enrollment form.
Please respond by: [Month XX, 2010]	Respond by date will change based on marketing date.
[123-103B] [5060002091717] [MZ2000104/0000F & 0001F]	These are company codes used internally to process enrollments and to uniquely identify solicitations
[HOW TO ACTIVATE COVERAGE] 1. [Select amount of coverage you want] 2. [Complete your information] 3. [Sign, date and return entire form]	These are instructions provided to the customer for completing the enrollment form when the policyholder offers choices in coverage.

[The monthly costs for the first [30] days of coverage will be paid for by [Wells Fargo Bank]]	This language is used when the policyholder/participating group is paying the initial premium for the first 30, 60 or 90 days. The application may be used with other group policyholders.

[o $100 per day] [o $200 per day] [o $300 per day] [Plan 1] [Plan 2] [Basic] [Bronze] [Enhanced] [Silver] [Deluxe] [Gold] [Premier] [Platinum]	Marketers may offer various benefit choices. Ranges of amounts offered are the same as on the Certificate Schedule of Insurance. Each plan may be listed with various titles, including but not limited to the titles and plans listed.
Bar code for scanning purposes	Holds customer information for company processing

[Group Accident Hospital Indemnity Plan] [Accident Care] [5 Way Medical] [Insurance] [Plan]	Marketer may want to add a branded name to the product.
[After the first 30/60/90 days,]	Option will be used if sponsor pays for the first month(s) of coverage.
[processed] and [billed] [quarterly] [and remitted directly to the Insurance Company from my [Wells Fargo Bank] [credit card][checking account].	Options that may be used for frequency and method of premium payment
I authorize my lending institution to collect the premium with my monthly mortgage payment [after my first [2 months] of no-cost coverage].	Authorization used when premium is to be paid with a mortgage payment.
[I understand I am providing the information on this form directly to Stonebridge Life and Stonebridge Life's Plan Administrator, neither of which are affiliated with [Wells Fargo Bank], to activate my coverage.	Some policyholders require this language to be used.
[This insurance product is not a deposit; not FDIC insured; not insured by any federal government agency; and is not guaranteed by the financial institution/affiliate.] **[The insurance product is: not FDIC or other government agency insured; not a deposit in, obligation of, guaranteed or underwritten by any bank or bank affiliate; not a condition of any banking service.]** **Insurance is not insured by the FDIC, any other agency of the United States, the bank or its affiliates; is not a deposit or other obligation of the bank or its affiliates; and is not issued, guaranteed, or underwritten by the bank, its affiliates or the FDIC.** **[Insurance is not a deposit or other obligation of the bank or any bank affiliate; is not guaranteed, issued or underwritten by the FDIC, the bank or any bank affiliate; is not insured by the FDIC or any other agency of the US, the bank or any bank affiliate; and is not a condition to the provision or term of any banking service or activity.]**	The FDIC disclosure language may vary based on the policyholder requirements.

SERFF Tracking Number:	*AEGX-G126708376*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*46138*
Company Tracking Number:	*AR0055900004*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Hospital Indemnity*		
Project Name/Number:	*Hospital Indemnity/AR0055900004*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/06/2010	Form	Group Accident Indemnity Certificate	07/22/2010	SLHAP1000GC.PDF (Superceded)

Stonebridge Life Insurance Company

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075]

CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No.[25XXX GCXXX] to [XYZ Corporation] (herein called Policyholder) which makes available accident medical indemnity insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return this Certificate of Insurance within [30/60/90] days after its receipt to us at our Administrative Office. If the Certificate is returned, insurance under the Policy shall be deemed void from the Certificate's Effective Date. Any premium you have paid will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

[This Certificate supersedes any Certificate previously issued to you under the Policy. You and any Covered Person may qualify under one Certificate only. If any person is insured under more than one Certificate, we will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any duplicated payments which may have been made on behalf of that person.]

GUARANTEED RENEWABLE TO AGE 100

Prior to the expiration of the Grace Period of your Certificate, the payment of the renewal premium is required to keep the Certificate in effect.

You may keep the Certificate in force until the Certificate anniversary date following your age 100. We do not have the right to:
1. cancel your coverage; or
2. place any restriction on your coverage while it is in force; or
3. refuse a premium paid on or before the date due or within the Grace Period.

This Certificate is signed for Stonebridge Life Insurance Company by its Secretary and its President.

Craig D. Vermie
Secretary

Marilyn Cerp
President

GROUP ACCIDENT INSURANCE
PROVIDING ACCIDENT HOSPITAL INDEMNITY BENEFITS
RENEWABLE TO AGE 100

Stonebridge Life Insurance Company

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25517 GCXXX] to [XYZ Corporation]

[PARTICIPATING GROUP NUMBER: XXXXXX

PARTICIPATING GROUP: XXXXXXXXX]

CERTIFICATE NUMBER: [82A1000000]

EFFECTIVE DATE: [6-01-2010]

INSURED: [JOHN DOE
221 ANYSTREET
APARTMENT 1231
ANYTOWN, USA 12345]

[INITIAL PREMIUM:] [$1.00]
MONTHLY PREMIUM: [$XX.XX]

[FAMILY COVERAGE]: [YES]

[PREMIUM CONTRIBUTION]: [100% AFTER THE FIRST [1][2][3] MONTHS]

	BENEFIT	AMOUNT [INSURED]	[SPOUSE]	[EACH CHILD]
A.	ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT	[$ 100-$500] [PER DAY]	[$ 100-$500] [PER DAY]	[$ 50-$250] [PER DAY]
	[MAXIMUM NUMBER OF DAYS [PER COVERED PERSON]]:	[[60-365]DAYS]		
B.	ACCIDENT DAILY INTENSIVE CARE UNIT BENEFIT	[$ 200-$1000] [PER DAY]	[$ 200-$1000] [PER DAY]	[$ 100-$125] [PER DAY]
	[MAXIMUM NUMBER OF DAYS [PER COVERED PERSON]]:	[[60-365] DAYS]		
C.	ACCIDENT DAILY OUTPATIENT BENEFIT	[$ 50-$250] [PER DAY]	[$ 50-$250] [PER DAY]	[$ 25-$125] [PER DAY]
	[MAXIMUM NUMBER OF TIMES PAID EACH CALENDAR YEAR [PER COVERED PERSON]]:	[3-10]		
D.	ACCIDENT DAILY PHYSICIAN VISIT BENEFIT	[$ 20-$100] [PER DAY]	[$ 20-$100] [PER DAY]	[$ 10-$50] [PER DAY]
	[MAXIMUM NUMBER OF TIMES PAID EACH CALENDAR YEAR [PER COVERED PERSON]]:	[3-10]		
E.	ACCIDENT AMBULANCE BENEFIT	[$ 50-$250] [PER TRIP]	[$ 50-$250] [PER TRIP]	[$ 25-$125] [PER TRIP]
	[MAXIMUM NUMBER OF TRIPS PAID EACH CALENDAR YEAR [PER COVERED PERSON]]:	[3-10]		

BENEFITS FOR ALL COVERED PERSONS WILL REDUCE BY ONE-HALF (50%) OF THE AMOUNTS LISTED ABOVE IF, BEFORE THE DATE OF INJURY, A COVERED PERSON ATTAINS AGE 80.

DEFINITIONS

INSURED (herein called "you," "your," or "yours") means you, the insured named in the Schedule of Insurance, provided coverage has become effective.

COVERED PERSON means, for coverage purposes only, you [and the following persons,] provided coverage has become effective[.][:

1. your lawful spouse; and
2. each of your unmarried children including step-children, children born to you or legally adopted by you, 25 years of age or younger. (An adopted child is a child who is in your custody pursuant to an interim court order of adoption or placement of adoption or newborns to be adopted if the petition fro adoption is filed within 60 days after the birth.)]

HOSPITAL means an institution which is a short term acute care general hospital. Its main purpose must be to provide medical care and treatment to injured persons as Resident Patients. It must have facilities on premises for major surgery, medical diagnosis and treatment by or under the supervision of one or more licensed Physicians. It must provide 24 hour a day nursing service by or under the supervision of a registered nurse. It must have organized departments of medicine. It may not include a hospital operating primarily as a rest, convalescent, extended care, chronic or skilled nursing facility; home for the aged; a place for the care and treatment of drug addicts or alcoholics, or a mental institution; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, whether or not such a facility is part of a hospital, as defined herein, or is an entirely separate facility.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being a Resident Patient in a Hospital for Necessary Treatment of an Injury. Such confinement must be prescribed by a Physician.

Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

INTENSIVE CARE UNIT means a specially equipped intensive care unit or cardiac unit located in a segregated section of a Hospital. It provides registered graduate nursing care. It must provide constant audio visual observation for patients who are in critical or serious condition. A daily intensive care fee is charged for room and board. Life saving drugs and equipment must be immediately available or on a standby basis.

RESIDENT PATIENT means a Covered Person who is confined in a Hospital as a registered bed patient and who is provided at least one day of room and board. A Covered Person is considered to be a resident patient each day of Confinement in the Hospital except for the day of discharge; unless a room and board charge is made for that day. This does not include Confinement if it is not for Necessary Treatment or if the Hospital is used primarily as a place for rest, nursing, convalescence or extended care.

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat Injuries. Such person must be providing services within the scope of his or her license. A physician may not be you or a member of your Immediate Family.

IMMEDIATE FAMILY means your spouse, parent, child, brother or sister, or any person living with you.

INJURY means bodily harm caused by an accident which occurs while this Certificate is in force resulting directly and independently of all other causes.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any Confinement, operation, treatment, or service not a valid course of treatment recognized by an established medical society in the United States is not considered necessary treatment. No treatment or service in connection therewith, which is experimental in nature, is considered necessary treatment.

We may use peer review organizations or other professional medical opinions to determine if health care services are:

1. medically necessary; and
2. consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. provided in the most economical and medically appropriate site for treatment.

Services will not be deemed necessary treatment if these criteria are not met.

TRAUMA CENTER means a facility which is licensed to service medical emergencies requiring urgent treatment. It does not refer to a Physician's office or birthing center.

URGENT CARE CENTER means a freestanding facility which is licensed to service medical emergencies requiring urgent treatment. It does not refer to a Physician's office or birthing center.

[**AEGON AFFILIATE** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

[**PARTICIPATING GROU**P is the organization named in the Schedule of Insurance.]

WHEN YOUR INSURANCE BEGINS

Each eligible person will become insured under this Certificate at 12:01 a.m., Standard Time on the Certificate Effective Date following acceptance by us of the enrollment form, if required, and upon receipt of the first premium [before/within 21 days of] the Certificate Effective Date. The premium and the Effective Date of Coverage are shown in the Certificate Schedule of Insurance.

[Newborn children are covered immediately from birth. Any required premium must be paid within 31 days. (See the Newborn Children provision.)]

Issuance of a Certificate is not a waiver of any of the above conditions.

WHEN YOUR INSURANCE ENDS

Coverage ends on the earliest of:

1. the Certificate anniversary date following your age 100 (See Continuation of Coverage);
2. the date you die (See Continuation of Coverage);
3. the last day of the period covered by your last premium contribution (See Grace Period); or
4. the date each Covered Person ceases to be a Covered Person as defined herein.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

COVERAGE

A. ACCIDENT DAILY HOSPITAL CONFINEMENT BENEFIT - We will pay the Accident Daily Hospital Confinement Benefit stated in the Schedule of Insurance beginning with the first day of Confinement for each day a Covered Person is Confined to a Hospital as a Resident Patient for at least 24 hours, provided 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) the Confinement occurs while this Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury.

The Accident Daily Hospital Confinement Benefit will begin with the first day of Confinement and continue for the number of days stated in the Schedule of Insurance.

Recurrent Confinements – To be covered, additional Confinements for the same Injury must take place within 90 days of the previously covered Confinement.

Simultaneous Confinement - We will pay an additional benefit equal to the Accident Daily Hospital Confinement Benefit stated in the Schedule of Insurance if you and your covered spouse are Confined as Resident Patients as the result of an Injury sustained in the same accident and such Confinement begins within 90 days from the date of the accident causing such Injury. This benefit will be payable for each day both you and your covered spouse remain Confined at the same time in a Hospital.

B. ACCIDENT DAILY INTENSIVE CARE BENEFIT - We will pay the Accident Daily Intensive Care Unit Benefit stated in the Schedule of Insurance beginning with the first day of Confinement for each day a Covered Person is Confined as a Resident Patient for at least 24 hours to an Intensive Care Unit as a result of a covered Injury provided 1) the Confinement is for the Necessary Treatment of a covered Injury; 2) the Covered Person is under the professional care of a Physician; 3) the Confinement occurs while this Certificate is in force; and 4) the Confinement begins within 90 days of the accident causing the Injury.

The Accident Daily Intensive Care Benefit will begin with the first day of Confinement and continue for the number of days stated in the Schedule of Insurance.

This benefit will not be paid in addition to the Accident Daily Hospital Confinement Benefit.

Any transfer from Accident Daily Intensive Care to Accident Daily Hospital Confinement or from Accident Daily Hospital Confinement to Accident Daily Intensive Care will not entitle a Covered Person to receive both benefits at the same time.

C. ACCIDENT DAILY OUTPATIENT BENEFIT: We will pay the Accident Daily Outpatient Benefit stated in the Schedule of Insurance when a Covered Person receives Necessary Treatment of an Injury in a Hospital emergency room, outpatient surgical facility, Trauma Center, Urgent Care Center, or free standing surgical facility. Only one benefit is paid per day up to the maximum number of times stated in the Schedule of Insurance. This benefit is not paid if the medical treatment or surgery occurs while the Covered Person is Confined as a Resident Patient in a Hospital or Intensive Care Unit Facility.

The Outpatient Surgery must occur within 90 days of the accident causing the Injury.

D. ACCIDENT DAILY PHYSICIAN VISIT BENEFIT: We will pay the Accident Daily Physician Visit Benefit stated in the Schedule of Insurance when a Covered Person visits a Physician for follow-up Necessary Treatment of an Injury. The treatment must be due to an Injury for which an Accident Daily Hospital Confinement Benefit, Accident Daily Intensive Care Unit Benefit, or Accident Daily Outpatient Benefit is payable. The benefit is not paid for Physician visits while the Covered Person is Confined as a Resident Patient in a Hospital or an Intensive Care Unit. Only one benefit is paid per day for the maximum number of visits stated in the Schedule of Insurance.

E. ACCIDENT AMBULANCE BENEFIT: We will pay the Accident Ambulance Benefit stated in the Schedule of Insurance up to the maximum number of trips stated in the Schedule of Insurance when a Covered Person is transported in an ambulance to or from a Hospital, Urgent Care Center, or Trauma Center to receive Necessary Treatment of an Injury for which the Accident Daily Hospital Confinement Benefit, Accident Daily Intensive Care Unit Benefit, or Accident Daily Outpatient Benefit is payable.

REDUCTION

All benefits in this Certificate and any riders, if attached, will reduce as shown in the Schedule of Insurance if, before the date of Injury, [you have][a Covered Person has] attained the age shown in the Schedule of Insurance.

EXCLUSIONS

No benefit shall be paid for Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (while sane in Missouri and Colorado);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person’s blood alcohol level being .08 percent weight by volume or higher;
5. the Covered Person’s operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person’s committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, disease, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

[CONTINUATION OF COVERAGE

In the event of your death, your covered spouse, if any, shall be deemed the Insured. Otherwise, the coverage will terminate on the next renewal date. If your spouse ceases to be your spouse for reasons other than your death, your spouse will no longer be covered as of the next monthly renewal date.

Coverage for any covered child insured under this Certificate shall terminate as of the next monthly renewal date after the covered child's marriage or the date the covered child is no longer a Covered Person as defined herein, whichever occurs first.

An unmarried covered child may continue to be covered upon reaching the limiting age as specified in the Covered Person definition, if:

1. the covered child is incapable of self-sustaining employment by reason of mental or physical handicap; and
2. dependent upon you for support and maintenance; and
3. you send us a written request for continuation of coverage within 60 days; and
4. you provide proof of incapacity as requested but no more than once annually; and
5. you pay the premium for adult benefits, if required.

Coverage may be extended for any covered child who is a full-time student at a postsecondary educational institution and who takes a Medically Necessary Leave of Absence until the earlier of one year or the date coverage would otherwise terminate under the contract terms. You must notify us and provide proof of Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is defined as a leave of absence from a postsecondary educational institution or a change in enrollment of the covered child that:

1. begins while the covered child is suffering from a serious illness;
2. is medically necessary; and
3. causes the covered child to lose student status for the purposes of coverage under this Certificate.]

[CONVERSION

The covered child or spouse whose coverage ceases may apply for his or her own certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new certificate will be issued:

1. on a form at that time with benefits most like but not greater than those of this Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of coverage under the new certificate will be the same as the effective date of the conversion. We will not pay under the new certificate for any Injury for which benefits have been paid under this Certificate.]

[NEWBORN CHILDREN

If your spouse or any children are already covered under this Certificate and a child is born to you, the benefit amount for the newborn child will be the same as for other children. If no other child is covered under this Certificate, the benefit will be the amount which would have been issued to children as of the effective date of this Certificate.

If neither your spouse nor another child is covered under this Certificate and if you wish to add child coverage, you must notify us of the child's birth within 31 days of the birth and pay the required additional premium. The child's benefit will be the amount which would have been issued to children as of the effective date of this Certificate. After the initial 31 days, the child will not be covered unless the required additional premium is paid in accordance with the provisions of this Certificate.]

PREMIUM

PAYMENT OF PREMIUM

All premiums due by the terms of the Policy shall be paid to our Administrative Office on or prior to the day they are due.

[For the first [two][three] month[s] of coverage, the premium will be paid by the [Policyholder/Participating Group].]

[After the first [two][three] month[s]], [you are required to contribute 100 percent of the premium payable for this Certificate.].

[If no initial premium is requested by us with your enrollment form, you shall have 21 days from the Effective Date shown in the Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21-day period, the Certificate shall be considered void from the beginning and no benefits will be paid for any Injury.]

If at any time the [Participating Group][Policyholder] refuses to accept such contributions and pay the premium for you, you may pay such premium directly to our Administrative Office on or prior to the day it is due.

PREMIUM CHANGES

All renewal premiums will be based on our rates in effect for this Certificate on the date such premiums are due.

We have the right to change the premium rates on any date. The new rates will be based on the ages of the Covered Persons on the dates they became insured. We will provide written notice at least 31 days before the date of change.

The premium rates may also be changed at any time the terms of the Group Policy are changed.

We will not increase your rates in the first Certificate year of coverage. After that, rates will not increase more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

The premium amount due may change when a Covered Person is added to or dropped from coverage or when benefits under this Certificate change. Any additional coverage is subject to our acceptance of the enrollment form, if required, and payment of any additional required premium.

GRACE PERIOD

If a premium is not paid when due, the insurance shall be in default. We will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate, effective the last day of the period covered by your last premium contribution.

REINSTATEMENT

Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45th day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only provides benefits for an Injury caused by an accident that occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

WHEN THERE IS A CLAIM

NOTICE OF CLAIM

Written notice of claim must be given to us within 30 days after any loss covered under this Certificate occurs or as soon as possible thereafter. The notice should include your name and Certificate Number as shown in the Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

CLAIM FORMS

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in this Certificate for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the date of the Loss or as soon as possible thereafter. Failure to produce proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within this time period. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

We will pay all benefits covered by this Certificate as soon as we receive proper written Proof of Loss sufficient to determine liability.

PAYMENT OF CLAIMS

All benefits are payable to you, if living. Unless you specify otherwise, any other benefit unpaid at your death will be paid as follows:

1. to your living lawful spouse; or if you do not have one,
2. in equal shares to your living lawful children; or if there are none,
3. in equal shares to your living lawful parents; or if there are none,
4. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of a legal adoption, lawful children and parents do not mean “step” children or parents.

PHYSICAL EXAM AND AUTOPSY

At our expense, we shall have the right to examine a Covered Person when and as often as is reasonable while a claim is pending. We may also have an autopsy done where it is not prohibited by law.

GENERAL PROVISIONS

ENTIRE CONTRACT

Your Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

INCONTESTABILITY

We cannot contest this Certificate except for fraud or for not paying premiums.

LEGAL ACTIONS

No action can be brought to recover on this Certificate for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

[OTHER INSURANCE

If a Covered Person is insured under more than one accident hospital indemnity policy or certificate in effect with us or any Aegon Affiliate at any one time, our maximum liability is limited to [a total of [5-20] certificates and policies with all Aegon Affiliates.] [[or] a total of [$25,000 - 400,000] for any one accident from all Aegon Affiliates]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to you or to your beneficiary.]